PRIOR AUTHORIZATION

ADULTS

Psychologist, Psychiatrist, PCNS, RHC, FQHC

The Psychology/Counseling bulletin, dated October 01, 2004, outlined a new Prior Authorization (PA) process. Prior Authorization approved the medical necessity of the requested service and does not guarantee payment. The recipient must meet eligibility requirements and the provider must be enrolled and eligible to bill the services.

Effective for dates of service November 01, 2004, and after, many psychological services provided to adults (21 years of age or older) must be prior authorized when performed by a psychiatrist, psychologist, psychiatric clinical nurse specialist (PCNS), rural health clinic (RHC), or federally qualified health center (FQHC).

Effective for dates of service May 01, 2005 and after Interactive therapy for adults is not allowed under the four (4) hours of non-prior authorized services. All Interactive therapy must be prior authorized.

Adult services provided by LCSWs and LPCs are not covered by Missouri Medicaid, except RHC/FQHC.

Family Therapy Without the Patient Present requires prior authorization for adults regardless of age.

CHILDREN

In subsequent phases, the Division of Medical Services (DMS) will implement new prior authorization measures for children for most psychology/counseling services.

Effective for dates of service May 01, 2005 and after, the PA process was implemented for children, 0 through 20 years of age, who are not in state custody or residing in a residential treatment facility.

The PA process for children in state custody or residing in a residential treatment facility will be implemented at a later date. Providers will be notified via bulletins regarding the effective dates for these groups of children.

The requirement for prior authorization will include services provided by a psychiatrist, psychologist, PCNS, provisionally licensed clinical social worker

(PLCSW), licensed clinical social worker (LCSW), provisionally licensed professional counselor (PLPC), licensed professional counselor (LPC), RHC, or FQHC.

ADULTS AND CHILDREN

Codes Requiring PA – Psychologist, Psychiatrist, PCNS, RHC, and FQHC

Assessment – Insight 90801 (30 minute session)
Maximum of 6 units per rolling year

Assessment – Interactive 90802 (30 minute session)
Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)
Individual Therapy 90806 / 90812 (45 – 50 minute session)
Maximum of 1 unit, either 30 minute or 45-50 minute session per day;
Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month

Family Therapy 90846 / 90847 (30 minute session)
Maximum of 2 units per procedure per day;
Maximum of 10 units per month

Group Therapy 90853 (30 minute session)
Maximum of 3 units per day;
Maximum of 15 units per month

Testing 96100 (60 minute session)
Maximum of 4 units per rolling year

Hypnotherapy 90880 (no time frame noted)

Aphasia Assessment 96105 (60 minute session)

Developmental testing 96111 (60 minute session)

Neurobehavioral testing 96115 (60 minute session)

Effective for dates of service 07-01-05 and after, 90899 unlisted psychiatric services or procedures will no longer be a payable code.

The AH modifier must be included when billing claims for psychologists.

Codes Not Requiring PA – Psychologist, Psychiatrist, PCNS, RHC and FQHC

Individual Inpatient	90816 / 90823 (20 – 30 minute session)
Individual Inpatient	90818 / 90826 (45 – 50 minute session)
Evaluation Inpatient Records	90885 (no time frame noted)
Evaluation and Management codes	
Crisis Intervention	**S9484 (60 minute session)**

Crisis Intervention

The definition of crisis intervention is: "the situation must be of significant severity to pose a threat to the patient's well being or is a danger to self or others". Crisis intervention services cannot be scheduled nor can they be prior authorized.

Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

CHILDREN

Codes Requiring PA – PLCSW, LCSW, PLPC, LPC

Assessment – Insight 90801 (30 minute session)
Maximum of 6 units per rolling year

Assessment – Interactive 90802 (30 minute session)
Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)
Individual Therapy 90806 / 90812 (45 – 50 minute session)
Maximum of 1 unit, either 30 minute or 45-50 minute session per day;
Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month

Family Therapy 90846 / 90847 (30 minute session)
Maximum of 2 units per procedure per day;
Maximum of 10 units per month

Group Therapy 90853 (30 minute session)
Maximum of 3 units per day;
Maximum of 15 units per month

Codes Not Requiring PA – PLCSW, LCSW, PLPC, LPC

Individual Inpatient 90816 / 90823 (20 – 30 minute session)

Individual Inpatient 90818 / 90826 (45 – 50 minute session)

Crisis Intervention S9484 (60 minute session)

Crisis Intervention

The definition of crisis intervention is: "the situation must be of significant severity to pose a threat to the patient's well being or is a danger to self or others". Crisis intervention services cannot be scheduled nor can they be prior authorized.

Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

GENERAL INFORMATION - GUIDELINES - Adults

Independent LCSWs and LPCs may not see adults and should not request prior authorization for psychology/counseling services for clients 21 year of age or older.

LCSWs and LPCs who are members of an FQHC or RHC may provide adult services as part of the clinic. These services will require prior authorization but the request is made using the facility provider number.

Psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

The first four (4) hours of psychotherapy services for adults do not require prior authorization. During this time the provider may see the recipient to determine if further visits are medically necessary. These four (4) hours may consist of testing, assessment, individual therapy, group therapy or family therapy with the patient present. The first four (4) hours is per recipient, per provider. Four (4) non-Prior Authorizations do not apply if providing family therapy without the patient present or individual interactive therapy, which requires Prior Authorization of all hours.

After the initial 4 hours, for services that are non-Prior Authorization is determined that ongoing services are medically necessary, prior authorization must be obtained. This prior authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial PA and any services requested after this will be considered continued treatment.

Approval will be based on the DSM IV-TR diagnosis code. Up to ten (10) hours of individual therapy will be authorized initially for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. Up to twenty (20) hours will be authorized initially for all other covered diagnosis codes. Family and group therapy will be approved for up to 10 hours for all covered mental health diagnoses.

The first request for PA can include individual therapy, testing, assessment, group family therapy. Testing, assessment, and group and family therapy must be identified separately.

If testing is requested, the allowed number of hours will depend on the number of hours approved based on the diagnosis code. Two (2) hours may be used for testing when approved for 10 hours and four (4) hours may be used for testing when approved for 20 hours. This is per recipient, per provider, per rolling year. Unit limitations apply for services whether used during the initial four (4) hours or as part of the prior authorized hours.

To request the initial 10 or 20 hours for most psychological services, you or a staff member may call (866) 771-3350. You should complete the Psychological Services Request for Prior Authorization form, as the information on this form will be required to complete the initial request for services. Telephoned requests will receive an approval or denial at the time of the call. If additional information is needed, the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.

To request continuing services beyond the initial authorization, the Psychological Services Request for Prior Authorization form must be completed and submitted along with the current Treatment Plan, current diagnostic assessment and copies of the last three (3) Progress Notes. This documentation may be faxed to (573) 635-6516 or mailed to Division of Medical Services, PO Box 4800, Jefferson City, MO 65102. Before requesting additional hours, 75% of the current authorized hours must be used.

All family therapy without the patient present and individual interactive therapy will require the PA Form, current diagnostic assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Only one (1) individual therapy PA and one (1) group or family PA per client will be issued at any time. If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the recipient's DCN, type of therapy to be closed and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

A client may have an open PA with one provider for individual therapy and a second PA open with the same or different provider for family or group therapy.

Most prior authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request prior authorization using the individual (49) provider number. However, authorization for services being rendered by a member of an FQHC must be requested by using the FQHC (50) provider number. Services being rendered by a member of an RHC must request prior authorization using the RHC (59) provider number.

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

Prior authorization is still required even when there is coverage through a third party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered third party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior authorization is required for clients residing in a nursing home but the psychology/counseling services may not be provided at the nursing home. **Psychiatrists and PCNS may provide pharmacologic management, procedure code 90862, in the nursing home setting.**

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior Authorization Exceptions

In-patient hospital stays

Crisis intervention

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse. If you are unsure that Medicare will pay, you must request a PA prior to rendering services, as Medicaid will not backdate a PA.

GENERAL INFORMATION - GUIDELINES – Children

The Division of Medical Services (DMS) has made PA requirement changes for psychological services for children and will be implementing additional changes for children. Previous policy, new policy changes, and planned changes are outlined below.

Effective November 01, 2004, individual therapy, family therapy with the patient present, and group therapy required prior authorization for children under the age of three (3) when performed by a psychiatrist, psychologist, and psychiatric clinical nurse specialist.

Effective November 01, 2004, family therapy without the patient present requires prior authorization when provided by a psychiatrist, psychologist, psychiatric clinical nurse specialist, regardless of the **age of the client**.

Family therapy without the patient present, regardless of the age of the child, has always required prior authorization when provided by an LCSW, LPC, PLCSW, PLPC, RHC, or FQHC. This policy remains in effect.

Prior authorization has always been required for individual therapy, family therapy with the patient present, and group therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC.

When requesting prior authorization psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

Testing services are not covered when provided by a PLCSW, LCSW. PLPC, or LPC regardless of the age of the client.

All services for children under the age of three (3) and family therapy without the patient present require the PA Form, current diagnostic assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed. **If requesting Prior Authorization for assessment or testing for a child under the age of 3, providers must submit clinical justification for providing services.**

An authorization number will be provided when Prior Authorization is requested and approved on a phone call. Services that require submission of the PA Form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior**

Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.

If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the client's DCN, the type of therapy to be closed, and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

Most prior authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request prior authorization using the individual (49) provider number. Authorization for services being rendered by a member of an FQHC (Federally Qualified Health Care) must be requested by using the FQHC (50) provider number and the performing provider name. Services being rendered by a member of an RHC (Rural Health Clinic) must request prior authorization using the RHC (59) provider number.

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

Prior authorization is still required even when there is coverage through a third-party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered a third-party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior authorization has always been required for individual therapy, family therapy with the patient present, and group therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC. This policy remains in effect.

Prior authorization is required for clients residing in a nursing home but the psychology/counseling services may not be provided at the nursing home. **Psychiatrists and PCNS may provide pharmacologic management, 90862, in the nursing home setting.**

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior authorization is required for psychological services provided on public or private school district grounds when billing to Medicaid. The provider must have a separate Medicaid provider number with a pay-to of the public school district.

Prior Authorization Exceptions

Inpatient hospital stays

Crisis intervention

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse. If you are unsure that Medicare will pay, you must request a PA prior to rendering services, as Medicaid will not backdate a PA.

New Prior Authorization Policy for Children 0 through 20

Effective May 01, 2005, the Division of Medical Services implemented a prior authorization process for all children birth (0) through 20 who are not in state custody or residing in a residential treatment facility. Prior authorization requirements for children in state custody or in a residential facility will be implemented at a later date.

The PA process includes services provided by a psychiatrist, psychologist, PCNS, PLCSW, LCSW, PLPC, LPC, RHC, and FQHC.

The first four (4) hours of psychological services for most children and services do not require prior authorization. During this time the provider may see the recipient to determine if further visits are medically necessary. These four (4) hours may consist of testing, assessment, individual therapy, group therapy or family therapy. The first four (4) hours is per recipient, per provider. The first four (4) non-Prior Authorization hours do not apply if providing services to children under the age of 3, Interactive Therapy, or family therapy without the patient present.

After the initial 4 hours, interactive therapy which requires Prior Authorization of all hours, when it is determined that ongoing services are medically necessary, prior authorization must be obtained. This prior authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial authorization and any services requested after this will be considered continued treatment. Except for those situations indicated above the preferred method of therapy may be requested by calling the Psychological Services Prior Authorization telephone number.

You or a staff member may place the call but the Psychological Services Request for Prior Authorization (PA) Form must be completed, as the information on this form will be required to complete the request for services. Telephoned requests will receive an approval or denial at the time of the call. If additional information is needed the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.

Prior authorization of psychology/counseling services for children is based on the age of the child and the type of therapy requested. Based on these limitations the first request for PA can include testing, assessment, individual, family, and group therapy.

If testing is requested the allowed number of hours will depend on the number of hours approved based on the diagnosis code. Two (2) hours may be used for testing when approved for 10 hours and 4 hours may be used for testing when approved for 20 hours. This is per recipient, per provider, per rolling year. Unit limitations apply for services whether used during the initial 4 hours or as part of the prior authorized hours. **If requesting prior authorization for assessment or testing for a child under the age of 3, providers must submit clinical justification for providing these services.**

To request continuing services after the initial authorization, the Psychological Services Request for Prior Authorization Form must be completed and submitted along with the current Treatment Plan, current diagnostic assessment and copies of the last three (3) Progress Notes. If the services being requested are court ordered, a copy of the court order must also be attached. Before requesting additional hours, 75% of the current authorized hours must be used.

Approval will be based on the DSM IV-TR diagnosis code. Up to ten (10) hours of individual therapy will be allowed for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. Up to twenty (20) hours will be allowed for all other covered diagnosis codes. Family and group therapy will be approved for up to 10 hours for all covered mental health diagnoses. The authorized number of

hours is based on the primary diagnosis. Documentation must support the diagnosis code.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. A Prior Authorization is not considered to be denied, if further documentation is required. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Children are best treated within the environment in which they live. Clinical evidence suggests family intervention is superior to individual therapy in treating children with many psychological disorders. Therefore, treatment should support the child within the family whenever possible. Clinical evidence also suggests treatment must be based upon age and cognitive development of the child. Best Practice approaches should insure the coordination of care when multiple providers are involved with the same child/family.

Group therapy uses group dynamics and peer interactions to increase understanding and improve social skills.

Multiple therapies would be defined as a request for more than one therapy such as, individual and family, simultaneously within the same authorization period. The treatment plan must document the medical need for more than one therapy. There is no procedure code that specifies multiple therapies are being requested.

When requesting prior authorization for multiple therapies the Prior Authorization Request Form must be completed and faxed or mailed, along with the requested documentation, to DMS. The PA request needs to indicate all types of therapy being requested.

If a child's age changes during the prior authorization period, the prior authorization will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if prior authorized.

Prior Authorization by Age Group

Psychology/counseling services for children under the age of 3, family therapy without the patient present and individual interactive therapy will not be allowed under the 4 hours of non-prior authorized service.

The preferred method of treatment is indicated first and if no documentation is required a telephone call may be made to request prior authorization. Services other than the preferred method and multiple therapies will require the PA Form and documentation be submitted via fax or mail.

Children Birth through 2

- Family therapy authorized initially with documentation and review
- Individual therapy will not be authorized
- Group therapy will not be authorized

Children 3 through 4

- Family therapy authorized initially without submitting documentation
- Individual therapy will not be authorized with the exception of interactive therapy with documentation and review. Your documentation must support interactive therapy is being provided
- Group therapy will not be authorized

Children 5 through 12

- Family therapy authorized initially without submitting documentation
- Group therapy authorized initially with documentation and review
- Individual therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 13 through 17

- Individual therapy authorized initially without submitting documentation
- Family therapy authorized initially without submitting documentation
- Group therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 18 through 20

- Individual therapy authorized initially without submitting documentation
- Family therapy authorized initially with documentation and review
- Group therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Prior authorization requests may be made by calling: (866) 771-3350
OR submitting the PA form and required documentation to:

Mail: Division of Medical Services
PO Box 4800
Jefferson City, MO 65102
Fax: (573) 635-6516

Prior Authorization Tips

Children under the age of 3 always require a PA form and documentation. Testing and assessment will also require clinical justification.

Call for approval on an initial prior authorization when the service does not require documentation.

If requesting prior authorization for multiple therapies fax or mail the PA form along with all required documentation even though it may be the initial request. When a PA request has been faxed or mailed allow sufficient time for the request to be reviewed. Do not send duplicate requests; expect at least five (5) days for a reply. You may call any/either of the following numbers to check on the status of a PA request:

Provider Communications	**(573) 751-2896**
Provider Education	**(573) 751-6683**

When faxing PA requests only send one (1) at a time. Multiple requests on the same fax must be handled differently and result in additional delay in response. Don't fax questions to the Psych Help Desk-send questions using the ask DMS e-mail Internet address.

Review the documentation requirements to insure all aspects have been included and that appropriate documentation is being submitted with your prior authorization request.

Documentation is required for all services for children under 3, multiple therapies, continuing therapy, and non-preferred therapy. The required documentation is the current diagnostic assessment, current Treatment Plan, and the last 3 Progress Notes. If the psychological services being requested are court ordered, a copy of the court order must also be attached to the documentation.

If a child's age changes during the authorization period the prior authorization will continue as authorized. **BUT** if the child turns 21 during the authorization period the policy for age restrictions will still apply even when services are prior authorized.

Prior Authorization requests will not be backdated. Allow sufficient time for submission and review of the PA and documentation. This includes enough time to resubmit the PA and documentation in the event the first submission is denied.

Daily and monthly limitations still apply even though an authorization has been approved.